サービス提供証明書

（介護老人保健施設における介護予防短期入所療養介護）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 公費負担者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 |  |  | 月分 |
| 公費受給者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 保険者番号 |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 被保険者 | 被保険者番号 |  |  |  |  |  |  |  |  |  |  |  | 事業者 | 事業所番号 |  |  |  |  |  |  |  |  |  |  |
| (ﾌﾘｶﾞﾅ)氏名 |  | 事業所名称 |  |
|  |
| 所在地 | 〒 |  |  |  | － |  |  |  |  |  |
| 生年月日 | 1.明治　2.大正　3.昭和 | 性別 | 1．男　2．女 |  |
|  |  | 年 |  |  | 月 |  |  | 日 |
| 要支援状態区分 | 要支援１・要支援2 |
| 認定有効期間 |  |  |  | 年 |  |  | 月 |  |  | 日 | から | 連絡先 | 電話番号 |
|  |  |  | 年 |  |  | 月 |  |  | 日 | まで |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 介護予防サービス計画 | ２.被保険者自己作成　３. 介護予防支援事業者作成 |  | 入所年月日 |  |  |  | 年 |  |  | 月 |  |  | 日 |
| 事業所番号 |  |  |  |  |  |  |  |  |  |  |  | 退所年月日 |  |  |  | 年 |  |  | 月 |  |  | 日 |
| 事業所名称 |  |  | 短期入所　実日数 |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 給付費明細欄 | サービス内容 | サービスコード | 単位数 | 回数日数 | サービス単位数 | 公費分回数等 | 公費対象単位数 | 摘要 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 合計 |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 緊急時施設療養費 | 緊急時傷病名 | ①②③ | 緊急時治療開始年月日 | ①②③ |  |  | 年年年 |  |  | 月月月 |  |  | 日日日 |
| 緊急時治療管理（再掲） |  | 単位 |  | 単位× |  |  | 日 |  |
| 特定治療 | ﾘﾊﾋﾞﾘﾃｰｼｮﾝ |  | 点 | 摘要 |
| 処置 |  | 点 |
| 手術 |  | 点 |
| 麻酔 |  | 点 |
| 放射線治療 |  | 点 |
| 合計 |  | 点 |
| 往診日数 |  |  | 医療機関名 |  | 通院日数 |  |  | 医療機関名 |  |

|  |  |  |
| --- | --- | --- |
| 特別療養費 | 傷病名 |  |
| 識別番号 | 内容 | 単位数 | 回数 | 保険分単位数 | 公費回数 | 公費分単位数 | 摘要 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 合計 |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 請求額集計欄 | 区分 | 保険分 | 公費分 | 保険分特定治療・特別療養費 | 公費分特定治療・特別療養費 |
| ①計画単位数 |  |  |  |  |  |  |  |  |  |
| ②限度額管理対象単位数 |  |  |  |  |  |  |  |  |  |
| ③限度額管理対象外単位数 |  |  |  |  |  |  |  |  |  |
| ④給付点数・単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑤点数・単位数単価 |  |  |  |  | 円／単位 |  | 10円／点・単位 | 10円／点・単位 |
| ⑥給付率 |  |  |  | ／100 |  |  |  | ／100 |  |  |  | ／100 |  |  |  | ／100 |
| ⑦請求額（円） |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑧利用者負担額（円） |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 特定入所者介護予防サービス費 | サービス内容 | サービスコード | 費用単価(円) | 負担限度額 | 日数 | 費用額(円) | 保険分 | 公費日数 | 公費分 | 利用者負担額 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 合計 |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 保険分請求額(円) |  |  |  |  |  |  | 公費分請求額 |  | 公費分本人負担月額 |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | 枚中 |  | 枚目 |